Supreme Court, U.S.
FILED
2001 AUG 0 1

(1)

No. 01-199

IN THE

Supreme Court of the United States

PACIFICARE OF CALIFORNIA, INC.,
PACIFICARE HEALTH SYSTEMS, INC., AND
GREATER NEWPORT PHYSICIANS, INC.,
Petitioners,

v.

BARBARA MCCALL,
Individually and as Trustee, etc.,
Respondent.

On Petition for a Writ of Certiorari to the Supreme Court of California

PETITION FOR A WRIT OF CERTIORARI

JON N. MANZANARES
GARY S. PANCER
KONOWIECKI & RANK LLP
Library Tower
633 West 5th Street
Suite 3500
Los Angeles, CA 90071-2007
(213) 229-0990

CARTER G. PHILLIPS*
RICHARD D. RASKIN
VIRGINIA A. SEITZ
SIDLEY AUSTIN BROWN & WOOD
1722 Eye Street, N.W.
Washington, D.C. 20006
(202) 736-8000

JEFFERY W. GRASS
DAVIS, GRASS, GOLDSTEIN & HOUSOUER
195 North Euclid Avenue
Second Floor
Upland, CA 91786
(909) 981-1820

Counsel for Petitioners

August 1, 2001

* Counsel of Record

WILSON-EPES PRINTING CO., INC. – (202) 789-0096 – WASHINGTON, D. C. 20001

134 pp

QUESTION PRESENTED

Whether Medicare beneficiaries may file a state court lawsuit against a Medicare contractor based on an allegedly wrongful denial of Medicare benefits without first administratively exhausting their claims and seeking federal judicial review as required under subsections 405(g) and (h) of the Medicare Act, 42 U.S.C. § 405(g) and (h), merely by styling their attack as a state law tort claim seeking consequential damages rather than Medicare benefits.

PARTIES TO THE PROCEEDING

All of the parties are listed in the caption of the case. Dr. Lakshmi Shukla was, with the petitioners, a defendant in the case below in the Supreme Court of California. Pursuant to Rule 29.6 of the rules of this Court, PacifiCare of California, Inc., is wholly owned by PacifiCare Health Plan Administrators, Inc., which is wholly owned by petitioner PacifiCare Health Systems, Inc. PacifiCare Health Systems, Inc., is publicly held, and Capital Group International, Inc., is the only publicly held company that owns 10% or more of its stock. Greater Newport Physicians, Inc., has no parent corporations, and no publicly held company owns 10% or more of its stock.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
PARTIES TO THE PROCEEDING	ii
TABLE OF AUTHORITIES	iv
OPINIONS BELOW	1
JURISDICTION	1
STATUTORY PROVISIONS INVOLVED	1
STATEMENT OF THE CASE	2
REASONS FOR GRANTING THE PETITION	10
I. THE CALIFORNIA SUPREME COURT'S DECISION CONFLICTS WITH DECISIONS OF THE FEDERAL COURTS OF APPEALS AND OF THIS COURT AND IS WRONG	13
II. THIS DECISION IS VITALLY IMPORTANT TO THE MEDICARE PROGRAM AND HENCE TO MILLIONS OF AMERICANS	25
CONCLUSION	30

TABLE OF AUTHORITIES

CASES Page

Affiliated Prof'l Home Health Care Agency v. *Shalala*, 164 F.3d 282 (5th Cir. 1999)..... 11, 17
Ardary v. *Aetna Health Plans of Cal., Inc.*, 98 F.3d 496 (9th Cir. 1996)..... 11, 18
Bodimetric Health Servs., Inc. v. *Aetna Life & Cas.*, 903 F.2d 480 (7th Cir. 1990) ...11, 14, 15, 16, 23
Booth v. *Churner*, 121 S. Ct. 1819 (2001)..... 21
Boyle v. *United Techs. Corp.*, 487 U.S. 500 (1988) 28
Cox Broad. Corp. v. *Cohn*, 420 U.S. 469 (1975)... 1
Franchise Tax Bd. v. *Construction Laborers Vacation Trust for S. Cal.*, 463 U.S. 1 (1983) 24
Heckler v. *Ringer*, 466 U.S. 602 (1984) .....*passim*
Jamaica Hosp. Nursing Home v. *Oxford Health Plans*, No. 99 CIV. 9541, 2000 WL 1404930 (S.D.N.Y. Sept. 26, 2000)..... 17
Matthews v. *Eldridge*, 424 U.S. 319 (1976) 21
Merrell Dow Pharms., Inc. v. *Thompson*, 478 U.S. 804 (1986)..... 24
Midland Psychiatric Assocs., Inc. v. *United States*, 145 F.3d 1000 (8th Cir. 1998) 11, 16
Pegram v. *Herdrich*, 530 U.S. 211 (2000)..... 23
Plocica v. *Nylcare of Texas, Inc.*, 43 F. Supp. 2d 658 (N.D. Tex. 1999) 19
Schweiker v. *Chilicky*, 487 U.S. 412 (1988) 12, 19, 21, 26
Shalala v. *Illinois Council on Long Term Care, Inc.*, 529 U.S. 1 (2000) .....*passim*
Smith v. *Kansas City Title & Trust Co.*, 255 U.S. 180 (1921)..... 24
United States v. *Erika, Inc.*, 456 U.S. 201 (1982).. 26
United Steelworkers v. *Rawson*, 495 U.S. 362 (1990) 24

TABLE OF AUTHORITIES – continued

Page

Wartenberg v. *Aetna U.S. Healthcare, Inc.*, 2 F. Supp. 2d 273 (E.D.N.Y. 1998) 19
Weinberger v. *Salfi*, 422 U.S. 749 (1975) ... 12, 19, 20, 25
Wilson v. *Chestnut Hill Healthcare*, No. Civ. A. 99-CV-1468, 2000 WL 204368 (E.D. Pa. Feb. 22, 2000) 17

STATUTES AND REGULATIONS

29 U.S.C. §185(a) 24
42 U.S.C. § 405 ..... *passim*
§ 1395 *et seq.* 3
§ 1395k 3
§ 1395*o* 3
§ 1395y(a)(1)(A) 3
§ 1395ff(b) 1
§ 1395ii 1
§ 1395mm 1, 3, 4, 28
42 C.F.R. § 417.101(a) 5
§ 417.106 5
§ 417.124 5
§ 417.418 5
§ 417.460 5
§ 417.461 5
§ 417.479 5
§ 417.606 4
§ 417.609 ..... 4, 5
§ 417.616 4
§ 417.617 5
§ 417.620 4
§ 417.632 4
§ 417.634 4
§ 417.636 4
§ 422.74 5
§ 422.111 5

TABLE OF AUTHORITIES – continued

	Page
42 C.F.R. § 422.152	5
§ 422.206	5
§ 422.208	5
§ 422.210(b)	5
§ 422.570	5

SCHOLARLY AUTHORITY

C. Wright, *Law of Federal Courts* (4th ed. 1983)	24

OTHER AUTHORITY

Robert Pear, *Medicare Shift Toward H.M.O.'s Is Planned*, N.Y. Times, June 5, 2001	28

PETITION FOR A WRIT OF CERTIORARI

PacifiCare of California, Inc., PacifiCare Health Systems, Inc., (collectively, "PacifiCare"), and Greater Newport Physicians, Inc. ("GNP") (all collectively, "petitioners") respectfully petition for a writ of certiorari to review the judgment of the Supreme Court of California in this case.

OPINIONS BELOW

The opinion of the Supreme Court of California (App. 1a-39a) was entered on May 3, 2001, and is reported at 21 P.3d 1189. The opinion of the Court of Appeal of the State of California, Fourth Appellate District, (App. 40a-52a) was entered on August 17, 1999, and is published in part at 87 Cal. Rptr. 2d 784. The order of the Superior Court of California, County of Orange, sustaining PacifiCare's demurrer was entered on August 4, 1998 (App. 55a-59a); and an order and amended order granting judgment to GNP were entered on August 3, and August 4, 1998, respectively (App. 60a-65a). None is published.

JURISDICTION

The opinion and final judgment of the Supreme Court of California on its jurisdiction were entered on May 3, 2001. This Court has jurisdiction pursuant to 28 U.S.C. § 1257. See *Cox Broad. Corp.* v. *Cohn*, 420 U.S. 469, 479-83 (1975).

STATUTORY PROVISIONS INVOLVED

This case involves 42 U.S.C. § 405(g) and (h) (App. 67a-70a), which have been applied to the Medicare Act by 42 U.S.C. §§ 1395ff(b), 1395ii, and 1395mm(c)(5)(B).

42 U.S.C. § 405(g) provides in pertinent part that:

> Any individual, after any final decision of the [Secretary] made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of

> such decision or within such further time as the Secretary may allow. Such action shall be brought in the district court of the United States for the judicial district in which the plaintiff resides, or has his principal place of business . . . .

42 U.S.C. § 405(h) provides that:

> The findings and decision of the [Secretary] after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the [Secretary] shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the [Secretary], or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

STATEMENT OF THE CASE

1. In this case, the California Supreme Court held that a Medicare beneficiary who did not exhaust federal administrative remedies nevertheless may file state law claims against a Medicare contractor "arising out of its refusal to provide services under a Medicare-subsidized health plan." App. 1a. The court thus allowed a state court lawsuit based on the HMO's alleged failure to provide Medicare benefits and fulfill other duties under the Medicare Act to proceed, even though the Medicare beneficiary had not challenged the failures through the process administered by the Secretary of Health and Human Services ("the Secretary") and the Health Care Financing Administration ("HCFA").[1]

2. The facts alleged in the Amended Complaint are straightforward. Respondent George McCall was a Medicare beneficiary. Medicare is a two-part federal health insurance program for people 65 and older and for certain disabled

---

[1] In June 2001, HCFA changed its name to the "Center for Medicare and Medicaid Services," but the petition refers to this entity as HCFA.

individuals. See 42 U.S.C. § 1395 *et seq.* A Medicare beneficiary may elect to receive health care on a fee-for-service basis in which the patient obtains medical care from a physician who submits a bill to a Medicare carrier. In the alternative, a Medicare beneficiary may enroll with an HMO that has a contract with HCFA to provide services to Medicare enrollees. *Id.* § 1395mm.[2] Respondent McCall elected to receive his Medicare benefits by enrolling in PacifiCare, an HMO. His primary care physician was Dr. Shukla and his physician provider group was GNP.

The Medicare Act covers, *inter alia*, the costs of hospitalization and related expenses that are "reasonable and necessary" for the diagnosis and treatment of illness or injury. See *id.* §§ 1395y(a)(1)(A), 1395k, 1395*o*. McCall, who suffered from progressive lung disease, sought approval from PacifiCare and GNP to receive a lung transplant. PacifiCare and GNP, however, allegedly determined that the requested lung transplant was not a reasonable and necessary treatment for McCall's condition. See App. 2a ("[a]llegedly, Dr. Shukla, PacifiCare and GNP repeatedly refused to refer Mr. McCall to a specialist for a lung transplant or provide other needed care, and ultimately forced him to disenroll from PacifiCare in order to get on the Medicare list for a transplant").[3]

---

[2] Medicare HMOs may cover additional benefits (such as dental, vision, or pharmaceutical) beyond those covered by fee-for-service Medicare, but they always provide at least those covered by the latter.

[3] More specifically, McCall's allegation is that he "wanted to go to the best facility [for a lung transplant]" which he believed to be the University of California at San Diego ("UCSD"), and that PacifiCare "refused to pay for the best facility," instead covering lung transplants at the UCLA and Cedar-Sinai hospitals. *See* McCall Dep. at 280-81 (July 7, 1988) (lodged with the Court). *See id.* at 281 (stating that he was "not now saying that [PacifiCare] refused to pay for a lung transplant . . . just saying that [PacifiCare] refused to pay for a lung transplant . . . at UCSD").

Under the Medicare Act, as Medicare providers, PacifiCare and GNP are required to "provide meaningful procedures for hearing and resolving grievances between the organization . . . and members enrolled with the organization." 42 U.S.C. § 1395mm(c)(5)(A). And, a "member enrolled with an eligible organization under this section *who is dissatisfied by reason of his failure to receive any health service to which he believes he is entitled* and at no greater charge than he believes he is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary." *Id.* § 1395mm(c)(5)(B) (emphasis supplied). The regulations implementing this section of the Act provide Medicare HMO enrollees with an appeal and review process that is virtually identical to that provided to Medicare fee-for-service enrollees – an HMO determination regarding coverage and payment (42 C.F.R. § 417.606), an internal review process upon request for reconsideration (*id.* § 417.616), mandatory submission of adverse determinations to HCFA (*id.* § 417.620), hearing before an Administrative Law Judge upon request (*id.* § 417.632), an appeal to the Departmental Appeals Board (*id.* § 417.634), and, federal district court review (*id.* § 417.636). Critically here, the regulations also provide for expedited review of certain HMO determinations where the time frame of the routine process "could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function." *Id.* § 417.609(b).

McCall, however, did not follow the procedures of the Medicare Act in challenging the HMO's alleged refusal to provide him with a lung transplant. Instead, he disenrolled from PacifiCare and resumed coverage with a fee-for-service Medicare physician.[4] He and his wife also filed a state court action against PacifiCare, GNP and Dr. Shukla.

---

[4] While this case was on appeal, McCall's fee-for-service Medicare physician conducted tests and determined that the transplant was reasonable and necessary, and McCall received the transplant at UCSD. He died shortly thereafter. App. 2a n.1.

The McCalls' operative amended complaint alleged eight state law causes of action for damages based on violations of state law and federal regulatory duties (including duties set forth in regulations implementing the Medicare Act) and a ninth for injunctive relief from unfair business practices. App. 76a-93a. Each of the claims rested on the petitioners' alleged violations of duties under the Medicare Act. See Amended Complaint, *id.* Count 1 sought damages for negligence. Five of the duties alleged to have been violated in Count 1 are expressly *alleged* to arise from Medicare regulations. *Id.* at 76a-77a. The remaining five state-law duties all have clear analogues under the Medicare Act, see, *e.g.*, 42 C.F.R. § 417.101(a) (requiring Medicare provider to provide appropriate referrals); *id.* §§ 417.479, 422.206, 422.208 (limitations on physician incentive plans); *id.* §§ 417.617, 417.609, 422.570 (expediting certain beneficiary appeals); *id.* §§ 417.418, 417.106, 422.152 (requiring quality assurance program for Medicare providers); *id.* §§ 417.460, 417.461, 422.74 (providers' duties with respect to disenrolling a beneficiary). The remaining counts expressly relied on the alleged violations of the duties enumerated in Count 1.[5] The critical point is this: Each count was based on alleged

---

[5] Count 2 alleges that petitioners *willfully* "failed to secure for GEORGE [McCall] the health care services he reasonably needed, including a lung transplant" and failed to fulfill the other duties set forth in Count 1. App. 79a. Counts 3, 4, 5, and 6 allege that to qualify as Medicare providers and to induce McCall to enroll, petitioners made misrepresentations and perpetrated a fraud upon the government and McCall by stating that they would fulfill the duties set forth in Count 1. *Id.* at 80a-90a. Counts 7 and 8 allege that petitioners' failure to fulfill their duties under Count 1 and their misrepresentations and fraud concerning the same constitute intentional and negligent infliction of emotional distress. *Id.* at 90a-92a; *see also* 42 C.F.R. §§ 417.124, 422.111, 422.210(b). Finally, Count 9 alleges that petitioners' failure to fulfill their duties under Count 1 and their misrepresentations and fraud concerning the same are unfair business practices and should be enjoined. App. 92a-93a.

violations of duties under the Medicare Act, most notably the duty to provide coverage for a lung transplant at UCSD.

PacifiCare and GNP demurred on the ground that the McCalls' claims arose under the Medicare Act, and therefore that jurisdiction lies exclusively in federal court and only after exhaustion of the administrative process for review of claims arising under the Act. See 42 U.S.C. § 405(g), (h). The trial court sustained the demurrers on the grounds pled, and dismissed the McCalls' claims against PacifiCare and GNP. Dr. Shukla did not file a demurrer, and the court did not dismiss the action as against him. App. 42a n.1.

3. The Court of Appeal reversed in part. It acknowledged that "[t]he gravamen of [the McCalls'] complaint is that, to save money, Pacificare, GNP and Shukla, repeatedly refused to refer him to a specialist for a lung transplant, or provide other needed care, and ultimately forced him to leave the plan to get on the list for a transplant . . . . [and that] [d]uring that time his condition worsened." App. 41a. The court further recognized that if "[the McCalls' claims arose under the Medicare Act], they were required to first exhaust their administrative remedies and could thereafter only seek judicial review in federal court." *Id.* at 43a. Finally, the court understood that a claim arises under the Medicare Act whenever "'"both the standing and the substantive basis for the presentation"'" of a claim is the Medicare Act or when a claim is "'"inextricably intertwined"'" with an alleged violation of duties under the Medicare Act. *Id.* at 44a, 45a (quoting *Heckler* v. *Ringer*, 466 U.S. 602, 615 (1984), and *Redmond* v. *Secure Horizons, Pacificare, Inc.*, 60 Cal. App. 4th 96, 102 (1997)).

The Court of Appeal nonetheless held that although the McCalls' claims "*depend* upon entitlement to benefits under the Medicare Act," App. 45a, they did not arise under the Medicare Act. The court held that "[w]here a state law claim is brought against an HMO, even if the claim is based on a denial of Medicare benefits, federal courts distinguish

Heckler and allow the action to proceed in state court." *Id.* at 45a-46a (citing cases). "[S]tate law claims which do not seek reimbursement for Medicare benefits do not arise under the Medicare Act, and are actionable in state court." *Id.* at 47a. The court held that the McCalls should have been permitted to amend their complaint to eliminate claims for past and future medical expenses as damages and that, once they did so, the claims would not arise under the Medicare Act. *Id.* at 47a & n.2.[6]

4.(a) The Supreme Court of California granted PacifiCare's and GNP's petitions for review, but a divided court ultimately affirmed the decision of the Court of Appeal. Like the Court of Appeal, the supreme court recognized that the critical question was whether the McCalls' claims arise under the Medicare Act, because such claims "may be reviewed by no person, agency or tribunal except in an action brought in federal district court, and then only after exhausting administrative remedies as described above." App. 5a.

But, the supreme court held that the McCalls' claims did not arise under the Medicare Act, even though they were premised on the alleged violations of duties under that Act, because the McCalls did not seek reimbursement of benefits as damages and because their "alleged harms" could not "be remedied through the Medicare administrative review process." App. 12a. The court acknowledged that the HMO's rationale – "i.e., that the plaintiff's state tort law claims were inextricably intertwined with a Medicare claim because the alleged wrongfulness of the defendant's conduct depended on whether the plaintiff was, in fact, entitled to payment of her claim – has a certain logic." *Id.* But the court relied on a presumption that Congress did not intend to

---

[6] The court also held that, under state law, PacifiCare and GNP may be vicariously liable for the negligence of a member physician. App. 48a-50a. That holding, which was affirmed by the Supreme Court, *id.* at 19a, is not at issue in this petition.

preempt state regulation of the same subject matter "unless a contrary intent is made clear." *Id.* It found that "[n]o intent to displace state tort law remedies was expressed in the Medicare Act as it read at the time relevant to this case" and that the subsequent Balanced Budget Act of 1997 reinforced this conclusion by preempting only "state laws mandating benefits to be covered, mandating inclusion of providers and suppliers, and coverage determinations." *Id.* at 13a, 14a.

In a final footnote, the court attempted to distinguish contrary federal court of appeals cases, stating that the latter were "actions seeking tort damages for harm allegedly sustained as a result of improper denial of claims, not, as here, claims arising from violations of duties separate from the duty to pay Medicare benefits." App. 19a n.11.

(b) Two justices dissented. As their opinion summarized:

> Disregarding th[e] congressional mandate [that all denials of Medicare claims be reviewed through Medicare's administrative review process and then in federal court] and key United States Supreme Court authority, the majority opinion allows virtually any Medicare HMO plan enrollee to bring suit in state court to challenge an HMO's denial of Medicare benefits. Enrollees may bypass Medicare's exhaustion requirements simply by styling their challenges as claims for tort damages. As a result, questions regarding which medical procedures are or should be covered by Medicare may now be decided outside of Medicare's exclusive review process by California judges and juries on an ad hoc basis.
>
> . . . [T]oday's decision sets the stage for potential conflict between an award of state law tort damages following a determination in a state court that Medicare benefits were wrongly denied, on the one hand, and the possibility that an exhaustive administrative appeal, followed by federal court review, would determine that

> Medicare benefits were *not wrongly denied* in the particular case and in other comparable cases, on the other. The two cannot be squared . . . . [App. 20a.]

The dissent explained that "[t]aken together," this Court's decisions in *Heckler* v. *Ringer* and *Weinberger* v. *Salfi* "make clear that claims challenging an HMO's denial of reasonable and necessary health services covered by Medicare must undergo an administrative review for final decision prior to any judicial review to ensure Medicare's efficient and orderly functioning." App. 26a. Pertinent here, in rejecting the argument that the McCalls' claims arose under state tort law and *not* under the Medicare Act, the dissent relied on this Court's rejection of the analogous argument in *Salfi*. See *id.* (citing *Weinberger* v. *Salfi*, 422 U.S. 749, 764 (1975)) (holding that the beneficiary's claim arose under both the Constitution and the Social Security Act).

The dissent also relied on this Court's explanation that "'the purpose of the exhaustion requirement is to prevent "premature interference with agency processes" and to give the agency a chance "to compile a record which is adequate for judicial review."'" App. 26a (quoting *Ringer*, 466 U.S. at 619 n.12, quoting *Salfi*, 422 U.S. at 765). "That purpose is frustrated substantially when HMO plan enrollees are permitted to bypass the administrative process," because "'plaintiffs in effect call upon the court to play doctor in their cases. The prescribed HMO and agency decisionmaking procedures were designed to avoid that problem.'" *Id.* at 27a (quoting *Roen* v. *Sullivan*, 764 F. Supp. 555, 560-61 (D. Minn. 1991)).

The dissent further explained that the majority decision put the California Supreme Court in conflict with federal court of appeals decisions foreclosing state law claims relating to benefit reimbursement by Medicare contractors. These decisions make clear that a plaintiff cannot avoid the exhaustion requirement "'simply by styling its attack as a claim for collateral damages instead of a challenge to the underlying denial of benefits,'" even though that

administrative process might not afford the plaintiff full relief. App. 28a (quoting *Bodimetric Health Servs., Inc. v. Aetna Life & Cas.*, 903 F.2d 480, 487 (7th Cir. 1990)).

Under this authority, the dissent argued, the McCalls' claims arise under the Medicare Act:

> Critically, plaintiffs' ability to prevail on their state law causes of action inevitably turns upon a determination that plaintiff George McCall was entitled to a Medicare benefit, i.e., a lung transplant, and that PacifiCare had no right to deny such benefit because it was reasonable and necessary for treatment of his condition. The consequential damages sought by plaintiffs also are dependent upon such a determination. That being the case, plaintiffs' claims are "inextricably intertwined" with a Medicare benefits determination and are subject to Medicare's administrative review process. [App. 31a (citations omitted).]

See also *id.* at 33a ("the harm resulting from all of PacifiCare's alleged misconduct is inseparable from the harm resulting from its denial of the lung transplant [so] there appears no basis for finding any of the claims exempt from the administrative review process"). The majority's disregard of these points, the dissent stated, "all but assures that Medicare's administrative review process will cease to function as a meaningful limit on judicial review." *Id.* at 39a.

REASONS FOR GRANTING THE PETITION

Each of the McCalls' state law claims rests on an allegation that PacifiCare and GNP breached duties under the Medicare Act, primarily the duty to provide George McCall with a medically "reasonable and necessary" health service (a lung transplant), and that these failures injured him. The California Supreme Court held that state law claims "arising out of [a Medicare contractor's] refusal to provide services under a Medicare-subsidized health plan," App. 1a, do not "aris[e] under" the Medicare Act, 42 U.S.C. § 405(h), where

the Medicare beneficiary does not seek Medicare benefits as damages and cannot obtain complete relief through the Medicare review process. The court is wrong, and its error broadens an extant conflict in the lower courts, contravenes this Court's legal framework for determining when a claim arises under the Medicare Act, and endangers and disrupts the Medicare program.

In reaching its decision, the California court acknowledged that "some disagreement exists among state and federal courts on this question, which has not yet been addressed by the United States Supreme Court." App. 1a. It chose to follow the line of authority exemplified by the Ninth Circuit's decision in *Ardary* v. *Aetna Health Plans of California, Inc.*, 98 F.3d 496 (9th Cir. 1996). By doing so, it brought itself into conflict with decisions of three other Circuits holding that state and federal law claims dependent upon the lawfulness of Medicare determinations arise under the Medicare Act. See *Bodimetric Health Servs., Inc.* v. *Aetna Life & Cas.*, 903 F.2d 480, 487-88 (7th Cir. 1990); *Midland Psychiatric Assocs., Inc.* v. *United States*, 145 F.3d 1000, 1003 (8th Cir. 1998); *Affiliated Prof'l Home Health Care Agency* v. *Shalala*, 164 F.3d 282, 285 (5th Cir. 1999). These courts have explained that "a party cannot avoid the Medicare Act's jurisdictional bar simply by styling its attack as a [state and federal law] claim for collateral damages instead of a challenge to the underlying denial of benefits" or "the Medicare Act's goal of limited judicial review for a substantial number of claims would be severely undermined." *Bodimetric*, 903 F.2d at 487.

Moreover, the California decision cannot be reconciled with this Court's jurisprudence concerning subsections 405(g) and (h) and the administrative channeling requirement of the Medicare Act. Specifically, the California court held that the McCalls' claims need not be channeled for three reasons: (i) because they arise under state laws; (ii) because the McCalls do not seek Medicare benefits as damages; and (iii) because

the McCalls could not receive the consequential damages they seek in the administrative process. This Court, however, has expressly stated that none of these factors justifies circumvention of the administrative process. See *Heckler* v. *Ringer*, 466 U.S. 602, 618-19 (1984); *Weinberger* v. *Salfi*, 422 U.S. 749, 765 (1975); *Shalala* v. *Illinois Council on Long Term Care, Inc.*, 529 U.S. 1, 13 (2000); *Schweiker* v. *Chilicky*, 487 U.S. 412, 423 (1988). Instead, the Court has interpreted the channeling requirement broadly "to assure[] the agency greater opportunity to apply, interpret, or revise policies, regulations, or statutes without possibly premature interference by different individual courts." *Illinois Council on Long Term Care*, 529 U.S. at 13.

It was Congress' statutory scheme that occasioned this Court's forebearance. Medicare is a vast and complex federal program which provides health insurance coverage for approximately 39 million persons, see *infra* at 25, and the administrative channeling requirement is a critically important component of the program. The California court's roadmap for avoiding the administrative process will have profound and profoundly damaging consequences:

First, it allows virtually all Medicare beneficiaries to bring suit in state court to challenge a Medicare contractor's denial of Medicare benefits "simply by styling their challenges as claims for tort damages." App. 20a. Under the California court's regime, judges and juries will provide the initial review of Medicare benefits determinations and consequential damages may be awarded, directly contravening the congressional mandate of limited judicial review and remedies and dramatically increasing both the amount of litigation and the price tag of the Medicare program. *Second*, the decision effectively forecloses uniform interpretation and enforcement of Medicare. It permits inconsistent and fundamentally unfair treatment of similarly-situated beneficiaries, based on whether they seek administrative review or file a lawsuit and based on the state or federal

circuit in which they reside. *Finally*, if the decision is interpreted to apply only to *HMO* Medicare providers, it creates a relative disadvantage for such providers at a time when Congress has decided to encourage provision of Medicare benefits through managed care. The substantial harm that the decision inflicts on a central component of an important federal program warrants this Court's review.

All of this damage, moreover, is achieved by an erroneous and crabbed interpretation of the requirement that all claims "arising under" the Medicare Act be administratively exhausted. 42 U.S.C. § 405(h). A state law claim arises under the Medicare Act if it is "inextricably intertwined" with a Medicare benefits claim. *Ringer*, 466 U.S. at 614-15. Under this definition, claims that are predicated on the unlawfulness of a provider's conduct under the Medicare Act plainly arise under the Medicare Act within the meaning of section 405(h). The California Supreme Court's contrary conclusion "all but assures that Medicare's administrative review process will cease to function as a meaningful limit on judicial review," App. 39a, in contravention of congressional intent and this Court's precedent and with drastic, damaging effect on the Medicare program.

For all of these reasons, this Court should grant the petition for review.

I. THE CALIFORNIA SUPREME COURT'S DECISION CONFLICTS WITH DECISIONS OF THE FEDERAL COURTS OF APPEALS AND OF THIS COURT AND IS WRONG.

Recognizing that "some disagreement exists among state and federal courts on this question which has not yet been addressed by the United States Supreme Court," the California Supreme Court held that state and other federal claims "arising out of [a Medicare provider's] refusal to provide services under a Medicare-subsidized health plan" do *not* fall within Medicare's exclusive review provisions so

long as the beneficiary does not seek to recover Medicare benefits as damages and cannot obtain complete relief through the Medicare Act's administrative process. App. 1a. This decision – which allows Medicare beneficiaries to avoid the administrative exhaustion requirement of the Medicare Act "simply by styling their challenges as claims for tort damages," *id.* at 20a – widens a substantial and important conflict in the judicial interpretation of the Medicare Act and is in irreconcilable tension with decisions of this Court.

1. There is now a broad, established conflict among the lower courts on the question whether state and other federal claims that are predicated upon a finding that Medicare benefits were wrongly denied "arise under" the Medicare Act, or whether such claims are collateral to claims under the Medicare Act as long as the beneficiary does not seek benefits as damages and cannot obtain complete relief in the Medicare administrative process.

The principal case holding that state and other federal law claims dependent upon a Medicare benefits determination arise under the Act is *Bodimetric Health Services, Inc.* v. *Aetna Life & Casualty*, 903 F.2d 480 (7th Cir. 1990). There the plaintiff, Bodimetric, brought state and federal law claims of, *inter alia*, fraud, fraudulent concealment, negligent misrepresentation, breach of contractual relationship, and civil RICO against Aetna, a carrier under contract with HCFA to administer Medicare claims. Bodimetric alleged that Aetna adopted a restrictive approach to Bodimetric's Medicare claims, leading to the wrongful denial of many such claims and the consequent closure of many of Bodimetric's home health agencies. *Id.* at 482. Aetna moved to dismiss for lack of subject matter jurisdiction, asserting that Bodimetric's claims arose under the Medicare Act and thus had to be administratively exhausted. *Id.* at 483.

Relying on this Court's instruction that "the term 'arising under' [should be read] broadly," and that "claims arising under other statutes may be barred by section 405(h) if they

are also 'inextricably intertwined' with the benefits determinations under the Medicare Act," the Seventh Circuit agreed that exhaustion was required. *Id.* (quoting *Ringer*, 466 U.S. at 622-24). In words apposite here, the court held that:

> *[a] party cannot avoid the Medicare Act's jurisdictional bar simply by styling its attack as a claim for collateral damages instead of a challenge to the underlying denial of benefits.* If litigants who have been denied benefits could routinely obtain judicial review of these decisions by recharacterizing their claims under state and federal causes of action, the Medicare Act's goal of limited judicial review for a substantial number of claims would be severely undermined." [*Id.* at 487 (emphasis supplied).][7]

The court specifically rejected Bodimetric's arguments that its claims did not arise under the Act because it could not receive full relief for its state law tort and contract claims through the administrative process: "[T]o be sure, the ALJ reviewing a denied claim may consider substantively different

---

[7] As the Government explained in its Brief to the Seventh Circuit in *Bodimetric*:

> Plaintiffs cannot establish their case without addressing either directly or indirectly the correctness of Aetna's denials of the disputed claims because the amended complaint alleges that Aetna denied claims improperly and because the consequential damages plaintiffs seek to recover flow from the impropriety of the denials of the claims. Furthermore, . . . in any event Aetna would be entitled in defense of this action to establish that the denials of reimbursement in some or all of the claims that underlie the amended complaint were correct. [Brief of United States at 4, *Bodimetric Health Servs., Inc.* v. *Aetna Life & Cas.*, 903 F.2d 480 (9th Cir. 1990) (Nos. 89-1428, 89-1570) (citations omitted).]

Thus, the Government argued, the claims are "inextricably intertwined with whether Aetna's determinations of benefits as to these claims were correct. Plaintiff cannot alter that reality by the artifice of calling the amounts of the denied claims 'damages' and seeking to recover them from Aetna instead of from the Secretary." *Id.* at 5.

issues than might a state or federal judge reviewing a tort or contract claim, but the ALJ can provide relief to Bodimetric through the reversal of denied claims." *Id.* While the administrative process "may not afford Bodimetric all the relief it seeks pursuant to its state law claims," "Congress, through its establishment of a limited review process, has provided the remedies it deems necessary to effectuate the Medicare claims process." *Id.* at 487 n.5.

Similarly, in *Midland Psychiatric Associates, Inc.* v. *United States*, 145 F.3d 1000 (8th Cir. 1998), the plaintiff, Midland, brought claims for tortious interference with contract against Mutual of Omaha Insurance Company and for negligent supervision of contract under the Federal Tort Claims Act against the United States, based on Mutual's allegedly deliberate denial of Medicare claims in order to put Midland out of business. *Id.* at 1002. The court concluded "that hearing Midland's tortious interference claim against Mutual would mean reviewing the merits of Mutual's Medicare claims decisions"; that Midland's claim therefore arose under the Medicare Act; and that the court lacked jurisdiction to consider the claim because Midland had failed to exhaust its administrative remedies. *Id.* As the court explained, "[a] claim may arise under the Medicare Act even though, as pleaded, it also arises under some other law." *Id.* at 1004 (citing *Salfi*, 422 U.S. at 760-61). "[H]earing Midland's tortious interference claim would necessarily mean redeciding Mutual's Midland-related Medicare claims decisions," the court concluded, and the claim therefore arises under the Medicare Act and must be administratively exhausted. *Id.* See *id.* at 1005 (holding that Midland's negligent supervision claim against the United States arose under the Medicare Act because it alleged that the government negligently "allowed Mutual to deny Medicare claims wrongfully").

Finally, the Fifth Circuit, too, has made clear that a claim arises under the Medicare Act where, as here, a state or federal claim depends upon a decision subject to exhaustion

under the Medicare Act. In *Affiliated Professional Home Health Care Agency* v. *Shalala*, 164 F.3d 282 (5th Cir. 1999), APRO filed a lawsuit claiming that the defendants conspired to violate its right to due process and equal protection under the Constitution by arbitrarily terminating its status as a Medicare provider because it is an African-American owned enterprise. The court declared that:

> [T]o fully address APRO's claim that their due process and equal protection rights were violated through the improper enforcement of Medicare regulations, a court would necessarily have to immerse itself in those regulations and make a factual determination as to whether APRO was actually in compliance. Given the administrative nature of that inquiry, it cannot be reasonably concluded that APRO's claim is collateral to a claim for administrative entitlement. [*Id.* at 285.]

The court concluded that "there is little doubt that APRO's claim is 'inextricably intertwined' with a demand for benefits," and thus dismissed APRO's complaint pursuant to section 405(g). *Id.* at 286. See also *Wilson* v. *Chestnut Hill Healthcare*, No. Civ. A. 99-CV-1468, 2000 WL 204368, at *4 (E.D. Pa. Feb. 22, 2000) (mem.) ("courts must discount any 'creative pleading' which may transform Medicare disputes into mere state law claims, and painstakingly determine whether such claims are ultimately Medicare disputes").[8]

Each of the above cases reflects the respective court's recognition that where "a necessary element of [a] cause of action is a showing that [the provider's] decisions concerning the amount of benefits due on the claims at issue were *incorrect* under the Medicare Act," the claim "plainly does involve the 'amount of benefits' payable under the Medicare

---

[8] *Cf. Jamaica Hosp. Nursing Home* v. *Oxford Health Plans*, No. 99 CIV. 9541, 2000 WL 1404930, at *3 (S.D.N.Y. Sept. 26, 2000) (holding that claim for benefits presented as a contract claim arises under the Medicare Act).

Act," and must be channeled through the Act's administrative processes and judicial review provision. See United States' Brief in Opposition to the Petition for Certiorari at 12, *Bodimetric Health Servs., Inc.* v. *Aetna Life & Cas.*, No. 90-328 (U.S. filed Nov. 1990) ("United States' *Biometric* Opp."). In this case, however, the California Supreme Court rejected this legal framework and instead adopted the Ninth Circuit's approach in *Ardary*. See App. 8a-17a.

In *Ardary*, the heirs of a deceased Medicare beneficiary brought a state law tort action against a Medicare provider seeking compensatory and punitive damages (but not Medicare benefits), on the grounds that the provider improperly denied emergency medical services (an airlift to a superior hospital) and misrepresented its plan to the beneficiary. The provider moved to dismiss on the ground that the claims arose under the Medicare Act and therefore that the claims had to be administratively exhausted, but the court of appeals rejected its arguments for two reasons: First, the court held that the standing and substantive bases for the claims were "state common law theories and not the [Medicare] Act." 98 F.3d at 499-500. Second, "[a]lthough the [plaintiffs] concede[d] that their wrongful death complaint [wa]s 'predicated on' [the provider's] failure to authorize the airlift transfer," the court concluded that the state law claims were not "'inextricably intertwined' with the denial of benefits because the [plaintiffs] [we]re at bottom not seeking to recover benefits" and because the death of the beneficiary could "not be remedied by the retroactive authorization of payment of the airlift transfer." *Id.* at 500.

Similarly, in this case, despite recognizing the "logic" of the argument that a state tort law claim is inextricably intertwined with the Medicare Act where "the alleged wrongfulness of the defendant's conduct depend[s] on whether the plaintiff was, in fact, entitled to payment of [the] claim," the California Supreme Court rejected it. App. 12a. Instead, the court followed *Ardary* and determined that where

a beneficiary does not seek to recover benefits and where the harms suffered by the beneficiary cannot be remedied through the administrative process, the claims are merely collateral or incidental to the claim for Medicare benefits, do not arise under the Medicare Act, and need not be administratively exhausted. *Id.* See also *Plocica* v. *Nylcare of Texas, Inc.*, 43 F. Supp. 2d 658, 663-64 (N.D. Tx. 1999); *Wartenberg* v. *Aetna U.S. Healthcare, Inc.*, 2 F. Supp. 2d 273, 278-79 (E.D.N.Y. 1998).

There is now a stark and mature conflict among the lower courts on the issue presented by this case – whether state law claims that depend upon alleged violations of duties under the Medicare Act arise under that Act where the beneficiary does not seek benefits and could not obtain consequential damages in the Medicare administrative process. Particularly in light of the substantial importance of this question to the Medicare system and Medicare beneficiaries, see Part II *infra*, this Court should resolve the conflict.

2. The California Supreme Court's decision is also in irreconcilable tension with this Court's decisions in *Heckler* v. *Ringer*, 466 U.S. 602 (1984); *Weinberger* v. *Salfi*, 422 U.S. 749 (1975); *Shalala* v. *Illinois Council on Long Term Care, Inc.*, 529 U.S. 1 (2000); and *Schweiker* v. *Chilicky*, 487 U.S. 412 (1988), and therefore is both worthy of review and wrong. Specifically, the decision rests on premises that this Court has emphatically rejected in its cases interpreting subsections 405(g) and (h); and the result is fundamentally inconsistent with the analysis in those cases and their mandate that the phrase "arising under" be construed broadly, *Ringer*, 466 U.S. at 615.

First, the California court concluded that the claims at issue arise under state law and thus could not also arise under the Medicare Act. App. 15a. But, this Court has made clear that claims may arise under the Medicare Act, and thus be subject to its administrative processes, even though they also arise under some other law. See *Ringer*, 466 U.S. at 615

(explaining that a claim may arise under the Medicare Act even though it is "in one sense also a claim arising under the Constitution"); *Salfi*, 422 U.S. at 760 (holding that although "[i]t would . . . be fruitless to contend that appellees' claim is one which does not arise under the Constitution," it would be equally fruitless "to argue that this action does not also arise under the [Act]").

Second, the California Supreme Court concluded that the state law claims at issue did not arise under the Medicare Act because the plaintiffs did not seek benefits or reimbursement of benefits, but instead sought consequential damages for the violation of state law duties resulting from the denial of benefits and other alleged violations of McCall's rights under the Medicare Act. But, this Court made clear in *Ringer* that a Medicare beneficiary must administratively exhaust a claim arising under the Act even if the beneficiary does not seek payment of benefits as relief. In that case, one of the plaintiffs lacked a valid claim for reimbursement because he had not undergone the operation at issue and did not intend to do so unless a court set aside as unlawful the agency's "no reimbursement" determination. 466 U.S. at 614-16. This Court nonetheless held that his claim required a determination of his entitlement to benefits under the Medicare Act, arose under the Act, and had to be channeled through the administrative process. See *id.* at 623 ("today we explicitly hold that our conclusion that the claims of [the beneficiaries] are barred by § 405(h) is in no way affected by the fact that those respondents did not seek an award of benefits"); *Illinois Council on Long Term Care*, 529 U.S. at 12 (channeling is required "despite the absence of any request for [benefits]").

Third, the California Supreme Court concluded that no exhaustion is required when a beneficiary cannot receive consequential damages or other tort-based relief through the administrative process. But *Illinois Council on Long Term Care* also made clear that a claim arising under the Medicare Act must be exhausted even though the Secretary cannot

address all claims and provide all remedies sought by the plaintiffs:

> The fact that the agency might not provide a hearing for that *particular contention*, or may lack the power to provide one, is beside the point because it is the "action" arising under the Medicare Act that must be channeled through the agency. See *Salfi*, *supra* at 762. After the action has been so channeled, the court will consider the contention when it later reviews the action. And a court reviewing an agency determination under § 405(g) has adequate authority to resolve any statutory or constitutional contention that the agency does not, or cannot, decide, including, where necessary, the authority to develop an evidentiary record. [529 U.S. at 23-24 (string citations omitted).]

See also *Chilicky*, 487 U.S. at 428-29 (holding that even where administrative remedies do not provide complete relief for the beneficiary, both the alleged constitutional violation and the denial of benefits from which it arises are remediable, if at all, only through the federal administrative review process); *Matthews* v. *Eldridge*, 424 U.S. 319, 329-31 (1976) (holding that a beneficiary must present his claimed entitlement to benefits administratively and that a court may thereafter consider a constitutional challenge related to that entitlement). Cf. *Booth* v. *Churner*, 121 S. Ct. 1819, 1822 (2001) (inmate raising claim "with respect to prison conditions" and seeking only money damages must nonetheless exhaust administrative review process which cannot provide such relief).

Petitioners readily acknowledge that this Court has never expressly held that a state or other federal law claim predicated on the denial of Medicare benefits or other rights under the Medicare Act and seeking consequential damages rather than benefits "arise[s] under" the Medicare Act. This Court's legal framework for determining whether a claim

arises under the Medicare Act, however, simply cannot accommodate the decision below in this case.

Under this Court's decisions, the statutory mechanism for administrative and judicial review in the Medicare Act furnishes comprehensive and exclusive remedies for all claims "arising under" the Medicare Act. 42 U.S.C. § 405(h). This Court has made clear that direct judicial review is unavailable for claims "arising under" the Medicare Act; that the term "arising under" must be interpreted "quite broadly"; and that a claim arises under the Medicare Act where "both the standing and the substantive basis for the presentation" of the claim is the Medicare Act or where the claim is "inextricably intertwined" with a claim for Medicare benefits. *Ringer*, 466 U.S. at 615, 614. The joint effect of these statutory provisions as construed by this Court is preclusion of collateral attacks on Medicare Act determinations in independent lawsuits against Medicare contractors.

A state or other federal law claim that is predicated upon the unlawfulness of a Medicare benefits determination or the violation of other duties under the Medicare Act plainly "arises under" the Medicare Act, as interpreted by this Court. Here, the McCalls clearly could not recover damages for injuries allegedly sustained as a result of petitioners' actions without proving that petitioners wrongly determined that George McCall was not eligible for a lung transplant and violated other rights he possessed under the Medicare Act. For example, in order to establish his negligence claim, McCall would have to show that petitioners violated one of the duties owed to him, as alleged in Count 1 of the complaint. To determine the nature and scope of those duties, the state court would have to interpret and apply the Medicare statute and regulations. See *supra* at 5 (laying out the Medicare provisions establishing each of the duties alleged to have been violated in Count 1). The "intertwined" inter-relationship between McCall's claims and the Medicare program necessarily precludes judicial review of those claims

except after administrative consideration (and even then only in federal court).[9] Were the rule otherwise, Congress' channeling requirement and all of the purposes served thereby could be rendered meaningless.

Petitioners most certainly do not contend that a tort challenge to quality of care (such as a medical malpractice claim) would have to be channeled pursuant to subsections 405(g) and (h). But where, as here, the Medicare contractor makes a determination of eligibility for a Medicare benefit – *viz.*, a determination whether a particular service such as a lung transplant is medically reasonable and necessary – challenges to that eligibility determination must be administratively channeled under the Medicare Act. Cf. *Pegram* v. *Herdrich*, 530 U.S. 211, 229 (2000) (holding that challenges to a physician's pure treatment decisions that may affect eligibility are not preempted by ERISA, but that challenges to an HMO's eligibility decisions which "turn on the [ERISA] plan's coverage of a particular condition or medical procedure for its treatment" are preempted).

The California Supreme Court's decision, accordingly, not only broadens the existing conflict among the federal courts concerning whether state claims that are predicated upon a wrongful denial of benefits arise under the Medicare Act, it

---

[9] This conclusion is further reinforced by the language of section 405(h) which states that "[n]o findings of fact or decision of the [Secretary] shall be reviewed by any person, *tribunal*, or governmental agency except as herein provided." 42 U.S.C. § 405(h) (emphasis supplied). The McCalls effectively asked the state "tribunal" to "review[]" the unappealed eligibility and other Medicare-related decisions that petitioners made on behalf of the Secretary. *See id.* This is not the route "provided" for judicial review in the Medicare Act. *See also id.* (forbidding federal court to exercise diversity jurisdiction over claims arising under the Act); *Bodimetric*, 903 F.2d at 488-89 (same).

also conflicts with the logic of long standing precedent of this Court.[10]

* * * *

Review should be granted both to resolve the conflict among the lower courts on the nationally important question

---

[10] The California Supreme Court's decision is also in substantial tension with this Court's decisions defining the term "arising under" in other contexts. In interpreting the scope of federal question jurisdiction under 28 U.S.C. § 1331, this Court has long held that a state law claim arises under federal law when "federal law creates the cause of action or . . . the plaintiff's right to relief necessarily depends on resolution of a substantial question of federal law." *Franchise Tax Bd. of Cal.* v. *Construction Laborers Vacation Trust for S. Cal.*, 463 U.S. 1, 27-28 (1983). Indeed, under the rule established in *Smith* v. *Kansas City Title & Trust Co.*, 255 U.S. 180, 199 (1921) and oft repeated, it is settled that "arising under" jurisdiction exists where the plaintiff's "right to relief depends upon the construction or application of the Constitution or laws of the United States," even though the right asserted and the remedy sought by the plaintiff are State-created. *See also* C. Wright, *Law of Federal Courts* § 17, at 95-96 (4th ed. 1983); *Merrell Dow Pharms., Inc.* v. *Thompson*, 478 U.S. 804, 808-10 (1986). Consistent with this Court's interpretation of the same term in section 1331, the question whether the McCalls' claims arise under the Medicare Act turns on whether the McCalls' right to relief depends upon the construction or application of rights and duties under the Medicare Act. Plainly, it does. *See supra* at 5.

The Court has also often considered whether a state law tort or contract claim arises under section 301(a) of the Labor Management Relations Act, 29 U.S.C. § 185(a), which provides federal jurisdiction for suits for violation of collective bargaining agreements. Most recently, in *United Steelworkers* v. *Rawson*, 495 U.S. 362 (1990), this Court held that a claim arises under section 301 if it is based on a duty created by a collective bargaining agreement or otherwise "substantially dependent" upon the construction of a collective bargaining agreement and that this result cannot be avoided by characterizing a claim as a state law tort. *Id.* at 366-67, 371 (citing *International Bhd. of Elec. Workers* v. *Heckler*, 481 U.S. 851 (1987); *Allis-Chalmers Corp.* v. *Lueck*, 471 U.S. 202 (1985)). Similarly here, McCall's state law claims are "substantially dependent" upon the lawfulness of a Medicare benefits determination and thus arise under the Medicare Act.

presented and to forestall serious damage to this Court's established legal framework for analysis of subsections 405(g) and (h).

II. THIS DECISION IS VITALLY IMPORTANT TO THE MEDICARE PROGRAM AND HENCE TO MILLIONS OF AMERICANS.

In 2000, Medicare provided health insurance coverage for 39 million persons (one in seven Americans) and paid $217 billion in benefits. App. 20a (citing The Henry J. Kaiser Family Found., *Medicare At A Glance* 1 (Feb. 2001)). The importance of this case to the future administration of Medicare and, indeed, of Social Security generally[11] cannot be overstated. It has long been settled law that Medicare beneficiaries cannot sue Medicare carriers or fiscal intermediaries for claims "arising under" the Medicare Act without first exhausting their administrative remedies; moreover, the relief available to the beneficiary has generally been limited to an award of benefits. 42 U.S.C. § 405(g), (h). The California Supreme Court decision, however, creates a different rule – one that permits direct judicial review, with no limitation on remedies for Medicare beneficiaries. If this decision stands, the consequences for Medicare will be devastating.

First, as the dissent explained:

> [The decision] allows virtually any Medicare HMO plan enrollee to bring suit in state court to challenge an HMO's denial of Medicare benefits. . . . simply by styling their challenges as claims for tort damages. As a result, questions regarding which medical procedures are

---

[11] Subections 405(g) and (h) apply to claims arising under both the Medicare Act and the Social Security Act generally. *See, e.g., Salfi*, 422 U.S. at 760-61, 763. Thus, the damaging impact of the California court's decision will extend not only to Medicare, but also to the Social Security program generally.

> or should be covered by Medicare may now be decided outside of Medicare's exclusive review process by California judges and juries on an ad hoc basis. [App. 20a.]

Thus, under the California decision, judges and juries – not HCFA and the Secretary – will provide the initial review of benefit determinations made by HMOs contracting with Medicare. This result severely undermines the Medicare Act's mandate of administrative determination of Medicare claims with only limited judicial review. See *Ringer*, 466 U.S. at 619 n.12 ("the purpose of the exhaustion requirement is to prevent 'premature interference with agency processes' and to give the agency a chance 'to compile a record which is adequate for judicial review'") (quoting *Salfi*, 422 U.S. at 765); *Illinois Council on Long Term Care*, 529 U.S. at 24 ("[p]roceeding through the agency in this way provides the agency the opportunity to reconsider its policies, interpretations, and regulations in light of th[e] challenges"). Instead, contrary to congressional intent, judges and juries will "play doctor." App. 27a.

Second, the consequential damages resulting from a delay or denial of benefits may be significantly greater than the value of the Medicare benefits lost in many situations. The court's decision, accordingly, will be a strong inducement to litigation and substantially increase the costs of administering the Medicare program. Almost certainly, Medicare contractors will begin to authorize unwarranted benefits to avoid litigation based on their refusal to do so and the risk of judgments that include consequential damages. This outcome contravenes the congressional decision to limit litigation and confine remedies to those provided under the Act, which reflects a careful balancing of competing private and governmental interests. See *Chilicky*, 487 U.S. at 426; *United States* v. *Erika, Inc.*, 456 U.S. 201, 208 n.11 (1982) (the legislative history of section 1395ff shows that "the remedies provided by these review procedures shall be exclusive") (quoting S. Rep. No. 89-404, at 54-55 (1965) (emphasis omitted)).

> While the Medicare system may not afford the range of relief available under state law, it is designed to provide that coverage decisions are reviewed in a thorough and expeditious manner by HCFA or its agent, and by ALJ's and departmental review boards that have special expertise in such matters. It is not the prerogative of this court to second-guess the measured tradeoffs enacted by Congress. [App. 39a.][12]

If the rule established in the decision below survives:

> Virtually any disappointed Medicare or other Social Security claimant could recast his challenge to an administrative decision denying his claim for benefits into a challenge to conduct underlying that decision – and then seek damages for the underlying conduct. Allowance of state-law damage actions in these circumstances would therefore invite widespread disruption of the Medicare Program and other Social Security programs, divert scarce resources to such litigation, and result in monetary remedies beyond those Congress intended – thereby giving rise to either a drain on the Medicare Trust Fund to pay such judgments against intermediaries or (if the United States did not make the intermediaries whole) a substantial disincentive for organizations to take on the task of serving as an intermediary. [United States' *Bodimetric* Opp. at 18.]

---

[12] Indeed, as the dissenting California Supreme Court justices observed, in reviewing Medicare benefits claims, the Secretary may impose in addition to "'any other remedies authorized by law,'" civil monetary penalties and may suspend payment to or enrollment of a contracting HMO where, *inter alia*, the HMO "'fails substantially to provide medically necessary items and services that are required (under law or under the contract)'" or "'misrepresents or falsifies information that is furnished – [] . . . to the Secretary . . . or [] . . . to an individual'" App. 22a (omissions in original) (quoting 42 U.S.C. § 1395mm(i)(6)(A)(i) & (v)).

Cf. also *Boyle* v. *United Techs. Corp.*, 487 U.S. 500, 511-12 (1988) ("[t]he financial burden of judgments against the [government] contractors would ultimately be passed through, substantially if not totally, to the United States itself, since . . . contractors will predictably raise their prices to cover, or to insure against, contingent liability"). This decision, in short, will have a dramatic impact on federal funding of Medicare.

Congress and the current administration have recently made clear their determination to increase the number of Medicare beneficiaries in managed care.[13] But, under the California decision, the litigation and the costs entailed in providing benefits to Medicare beneficiaries will dramatically increase, and managed care contractors (already reluctant participants)[14] will be increasingly unwilling to provide Medicare benefits.

Third, there is a strong federal interest in the uniform interpretation of federal statutes generally, and the need for uniform determinations of benefits and rights under the Medicare Act is particularly compelling. The decision at issue inflicts substantial damage on the federal interest in the uniform interpretation and enforcement of the Medicare Act in two different respects.

Initially, it creates the very real possibility that a state court might award a Medicare beneficiary damages based on its view that benefits were wrongly denied, while "an exhaustive

---

[13] *See, respectively*, Balanced Budget Act of 1997, 42 U.S.C. § 1395mm(k) (enacting a new range of Medicare managed choice options effective January 1, 1999); Robert Pear, *Medicare Shift Toward H.M.O.'s Is Planned*, N.Y. Times, June 5, 2001, at A17 (reporting HCFA's announcement of the administration's determination to increase the number of Medicare beneficiaries in managed care).

[14] *See* Pear, *supra* ("[m]any H.M.O.'s have reduced their participation in Medicare, calling payments inadequate and regulations excessive. In the last three years, managed care plans have dropped more than 1.6 million Medicare beneficiaries").

administrative appeal, followed by federal court review, would determine that Medicare benefits were *not wrongly denied* in the particular case and in other comparable cases." App. 20a. A particular beneficiary thus could receive a substantial jury award based on a determination that Medicare benefits were wrongly denied or delayed while a similarly situated beneficiary who pursued an unsuccessful administrative appeal would receive nothing. Such a result is entirely antithetical to Congress' determination to create a federal benefit consistently administered and to secure that end by requiring that all claims arising under the Medicare Act be channeled through the administrative process. See *Illinois Council on Long Term Care*, 529 U.S. at 24 ("[p]roceeding through the agency in this way provides the agency the opportunity to reconsider its policies, interpretations and regulations in light of th[e] challenges").

Moreover, under the California decision, the varied law of individual states – rather than uniform federal law – will determine both whether a benefit should be provided and what the remedy should be for a failure to do so. This will result not only in increased state and federal court litigation, but also in unseemly forum shopping. A medical service may be medically reasonable and necessary under one set of circumstances in California, but not so under the same circumstances in other states (or not amenable to initial judge or jury determination at all in federal courts in Illinois or Iowa). It is fundamentally unfair for Medicare beneficiaries to be subject to different sets of rules based on nothing more than the fact that their claims are being litigated in different states or circuits. See also United States' *Bodimetric* Opp. at 9 ("there is no reason to believe that Congress would have intended to permit adjudicatory decisions made by persons responsible for administering a federal program that is pervasively regulated by federal statutory law to form the basis for personal liability under the varying common law of the States").

Finally, the California Supreme Court's decision may give rise to an irrational distinction between Medicare beneficiaries who choose a fee-for-service option and those who choose managed care, if it is interpreted to mean that only the latter are able to proceed directly to court and seek consequential damages for a benefit denial they view as wrongful. If that occurs, the costs and risks of providing HMO coverage to Medicare beneficiaries will rise relative to the provision of fee-for-service Medicare benefits, a result unsupported by statutory language and contrary to congressional intent and current policy goals. See *supra* at 13 & 14.

The Medicare program provides health care to millions of Americans and constitutes a significant sector of the health care industry. The outcomes described above are dangerous and disruptive to this vitally important program and to Medicare contractors, and are contrary to Congress' expressed will. Indeed, the dissenting California Supreme Court justices rightly concluded that the decision "all but assures that Medicare's administrative review process will cease to function as a meaningful limit on judicial review." App. 39a. The case is therefore of profound national importance, and this Court's review is warranted.

* * * *

A state law or other federal claim that is predicated upon a wrongful denial of Medicare benefits or a violation of other rights under the Medicare Act "aris[es] under" that Act and must be administratively exhausted and then reviewed exclusively in federal court. 42 U.S.C. § 405(h). The immediate and substantial harm inflicted upon an important federal program by the California Supreme Court's contrary ruling amply justifies certiorari review.

CONCLUSION

The petition for certiorari should be granted.

Respectfully submitted,

JON N. MANZANARES
GARY S. PANCER
KONOWIECKI & RANK LLP
Library Tower
633 West 5th Street
Suite 3500
Los Angeles, CA 90071-2007
(213) 229-0990

JEFFERY W. GRASS
DAVIS, GRASS, GOLDSTEIN & HOUSOUER
195 North Euclid Avenue
Second Floor
Upland, CA 91786
(909) 981-1820

CARTER G. PHILLIPS*
RICHARD D. RASKIN
VIRGINIA A. SEITZ
SIDLEY AUSTIN BROWN & WOOD
1722 Eye Street, N.W.
Washington, D.C. 20006
(202) 736-8000

Counsel for Petitioners

* Counsel of Record

August 1, 2001